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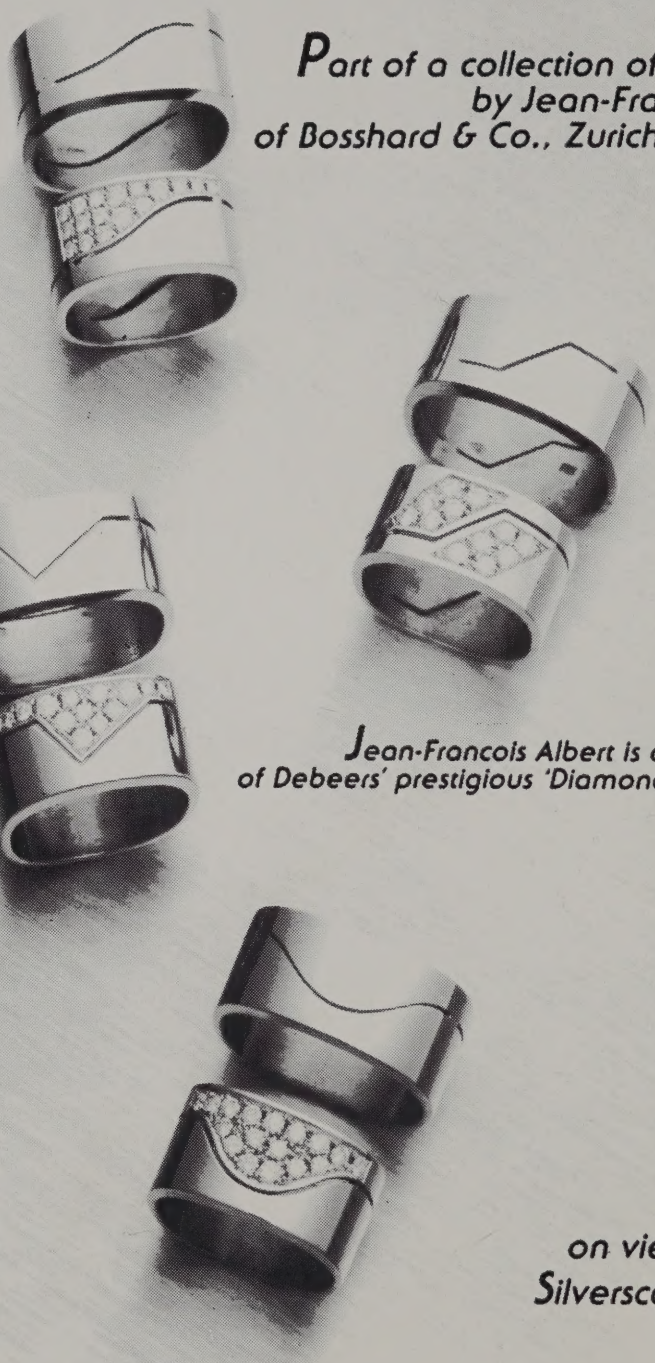

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THE HAMPDEN HIPPOCRAT

VOLUME XXXXII NO. 5
AUGUST - SEPTEMBER 1985

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Telephone: 736-0661

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Opinions expressed by authors are their own and not necessarily those of the Hampden District Medical Society.

HAMPDEN DISTRICT MEDICAL SOCIETY 1985-1986 SEASON

District Meeting

PLACE:	Sheraton-West West Springfield
DATE:	Tuesday, November 19, 1985
BUSINESS MEETING:	6:00 p.m.
SOCIAL HOUR:	7:00 p.m.
DINNER:	7:30 p.m. Courtesy of H.D.M.S. to members. Spouses are welcome.
SPEAKER:	Barbara A. Rockett, M.D., President Massachusetts Medical Society
SUBJECT:	"An Update of the Issues Affecting Medicine in Massachusetts"

NOTE: If you must cancel your dinner reservation, please call the office before noon on November 19th. If the cancellation is not made, you will be BILLED for your dinner.

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THE HAMPDEN HIPPOCRAT

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AUGUST — SEPTEMBER 1985

VOLUME XXXXII NO.5

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D., and William A.R. Chapin, M.D.

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THE HAMPDEN HIPPOCRAT is published bi monthly.
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All communications should be addressed to Carol L. Nystrom, Hampden District Medical Society, 1414 State St., Springfield, Mass. 01109: Telephone: 736-0661.
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HDMS President's Message

Professional Liability Crisis

Augusto G. Asinas, M.D., President

Summer is almost over and by now most of you are back from a well deserved vacation. I hope you all enjoyed the time together with your family and loved ones.

Presently we are faced with the most critical of issues and that is the ever increasing premiums for malpractice insurance. I am afraid it is reaching crisis proportions. The serious implications of these premium hikes go far beyond the medical practice. Some of our colleagues are taking an early retirement because of the escalating cost and others are going to full time work with medically related companies. It is a sad commentary: a great loss to our community! Those of us who are maintaining an active medical practice find it hard to keep abreast with the spiraling cost. We might have to take a second look at the voluntary freeze on medical fees.

What then must be done? We must impress upon our elected leaders in government, the legal profession, business and the general public for badly needed tort reform in order for medicine to be viable. Should we fail, I fear for the future of health care. The Massachusetts Medical Society tried its best to introduce tort reform bills in the Massachusetts House of Representatives but was able to get only three out of ten reported favorably. We should all, not just a few of us, write or talk to our governor and state representatives regarding this great dilemma.

We the physicians, as guardians of the public health, must strive to protect it at all cost. We can no longer allow health care to suffer in the hands of a litigious society! ■

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Return to Chicago

Hospital Medical Staff Section, American Medical Association

Report on the Annual 1985 Meeting

By Gregory A. Slachta, M.D.
Representative HMSS, Baystate Medical Center Medical Staff
President Elect, Hampden District Medical Society

A year has passed since I sojourned to the Windy City to represent the Baystate Medical Center's Medical staff at the now not so fledgling hospital staff section of the AMA.

I felt far more prepared since my last visit with a year of theoretical and practical experience with medical staff autonomy, joint venturing, malpractice, alternative health care delivery systems and legal status of the hospital staff issues under my belt.

Of course, the interim meeting in Honolulu last December softened the frustrations by the warm climate, but was perhaps the heralder of how hot things were to become. It was out there that we found out that the Federal Court of Appeals reversed Kartell vs. Blue Shield and shortly thereafter the Blues unilaterally implemented Masterhealth Plus right here in our back yard.

The issues have come so fast and furiously that it is a small wonder that we have lost our direction. Besides the above mentioned issues that are vastly important to the hospital medical staffs, there are issues we all share in dealing with Medicare and the delayed reimbursements from HCFA, the Medicaid access coalitions, and the retroactive JUA payments that will be required for our malpractice coverage.

As physicians we have been fragmented in the past by our diverse specialties, mode of practice and means of income. If there is one thing that comes through loud and clear at the national level of the Medical Staff Section, it is that our differences are less than they ever have been, that there is a commonality of purpose emerging and a new leadership developing.

It is clearer than ever that the profession must exert its professional and political muscle to preserve the quality of medical care this nation is used to and deserves.

Ten resolutions from the fifth assembly of the Hospital Medical Staff Section were sent to the AMA House of Delegates for action. Summarized then, are these actions:

1. Resolution 144 - Reducing Membership Dues

The resolution asked the AMA to approve reduced membership dues for physicians joining for the first time.

AMA Action: Referred to the Board of Trustees for further study and report back.

2. Resolution 145 - Underutilization Peer Review

This resolution requested the AMA to recommend that any plan creating incentives, financial or otherwise, to the Hospital Medical Staff physicians for reducing health care services be carefully checked by legal counsel for ethical considerations and legal consequences, and further, that such plans continue to be monitored by a committee of the medical staff for possible adverse effects on patient care. The reason for this resolution stems from a California hospital's plans to reimburse physicians a financial reward for saving the hospital money on DRG reimbursements with early discharge.

AMA Action: Substitute Resolution 145 was adopted in lieu of Resolution 145. The adopted substitute changed the wording by calling for such plans to be carefully reviewed by the medical staff for ethical considerations and by the medical staff legal counsel for legal consequences. The committee monitoring aspects referred to in the original resolution remained.

3. Resolution 146 - Double billing by physicians for interpretation of diagnostic procedures in emergency room settings.

The resolution called upon the AMA to study the issue of reimbursement for concurrent care, including the interpretation of diagnostic procedures in hospital settings, and report back at the 1985 interim meeting.

AMA Action: Referred to the Board of Trustees for further study.

4. Resolution 147 - Hospital Administrator at Medical Executive Committee Meetings.

This resolution asked that the AMA instruct its commissioners to work to ammend the joint commission on accreditation of Hospitals Medical Staff Standard II.D1(C) whereby: the chief executive officer of the hospital or his designee may be invited to attend each executive committee meeting on an

Continued on next page

Return to Chicago

Continued from previous page

ex-officio basis without vote; during executive sessions, the attendance may be requested or refused by the Medical Executive Committee.

AMA Action: The resolution was adopted as amended to remove any reference to ex-officio. In addition, the amended version clarified that it refers to executive committee meetings of the medical staff; and, during executive sessions the administrator or his designee may be invited to stay or asked to leave the meeting.

5. Resolution 148 - Declaration of National Medical Professional Liability Crisis Day.

This resolution proposed that the AMA declare a national Medical Professional Liability Crisis Day and request appropriate active observance by all United States physicians, state and county medical societies, and other supportive parties. It further asked that the goal of this effort is to inform the public of its vital stake in the professional liability problem from the standpoint of cost, quality and access to medical care and to indicate to state and federal legislators that this situation is negatively impacting on more of their constituents than physicians alone.

AMA Action: Not adopted. (The reason for not adopting was not because the crisis is not widespread, but rather it is primarily a state problem and some states have been making progress with their legislatures and felt this approach would be detrimental to their efforts).

6. Resolution 149 - Malpractice Crisis

This resolution called upon the AMA Board of Trustees to urge the Special Task Force on Professional Liability and Insurance to consider any and all means to inform the general public of the current and potential harm to the general public, especially the poor and elderly, if the present system of medical liability remains unaltered. It is further requested that the AMA appeal to the federal government and that the AMA urge constituent and component medical societies to consider appealing to the governor and legislature of each state to propose solutions to the professional liability situation. The resolution also asked the AMA and constituent and component medical societies to recommend methods by which parties with legitimate complaints may receive ample and just renumeration without deleterious effect on the entire system of health care delivery.

AMA Action: Resolution 149 was adopted as amended. The amended version asks the AMA Board of Trustees to urge the Special Task Force on Professional Liability and Insurance to consider all appropriate means to inform the public of the current and potential harm to the public of the present system of medical liability remains unimproved.

Furthermore, it asks the AMA and its component societies to modify or develop alternate methods to the court/jury system whereby parties who have been injured through negligence receive just remuneration without adversely affecting the entire health care delivery system.

7. Resolution 150 - Guidelines for Outpatient Surgery and Same Day Admission

The resolution asked the AMA to work to establish specific guidelines for both appropriate and inappropriate outpatient surgery and same day admissions and urge the government agencies and third party payors to follow these guidelines. It further asked that the AMA work with such groups as the American Hospital Association to redefine "Hospital Day" and to develop alternative services which promote quality care and more appropriate and beneficial use of outpatient and "same day" admissions.

AMA Action: Referred to the Board of Trustees for further study.

8. Resolution 151 - Position Statement on the Federal DRG Program

This resolution solicited the AMA to express its profound reservations about the overall impact of the Diagnoses Related Groups System on patient well-being and on the capability of hospitals providing quality of care, and also asked that the AMA continue to monitor the program and offer constructive recommendations, including changes in the prospective pricing system when appropriate, to assure the quality of care to patients.

AMA Action: Substitute resolution 151 was adopted in lieu of resolution 151. The adopted substitute calls for the AMA to encourage and support the testing of innovative reimbursement systems; asks the AMA to endorse for general application only those systems that have been appropriately and adequately tested and found to promote quality of care, as well as to be cost-effective. Furthermore, it asks the AMA to express its profound

reservations about the overall impact of DRGs on patient well-being and on the capability of hospitals to continue to monitor the system, and offer constructive recommendations to assure high quality care to patients.

9. Resolution 152 - Support for "Inner City" Hospitals

This resolution requested the AMA to investigate the suits brought by some "inner city" hospitals against the Department of Health and Human Services for failing to make adjustments in the Medicare payment rates for those institutions that serve a significantly disproportionate share of low income patients or Medicare patients; and further asked that if these suits are meritorious, the AMA consider supporting the hospitals in these suits.

AMA Action: Adopted.

10. Resolution 153 - The Report of the Joint Task Force on Hospital Medical Staff Relationships

The resolution called for the AMA to discontinue circulation of the "Report of the Joint Task Force on Hospital Medical Staff Relationship."

AMA Action: Substitute Resolution 153 was adopted in lieu of Resolution 153. The adopted substitute requests the AMA's office of general counsel to complete the state-by-state annotation of the "Legal Status of the Medical Staff" as quickly as possible, and to distribute this to each component society and each registrant at the most recent meeting of the AMA-HMSS and the AMA-HOD within 60 working days of the close of the house meeting.

In addition to the resolutions forwarded to the house for their consideration, the HMSS Assembly referred several resolutions to the HMSS Governing Council for study and report. The referred resolutions are on the following subjects:

Resolution 48 - Senior Care Voucher Review
Resolution 35 - Medical Staff Bylaws as Contract
Resolution 27 - Inherent Professional Authority of the Medical Staff
Resolution 15 - Responsibility and Accountability of the Board of Trustees vis-a-vis Medical Staffs
Resolution 23 - Medical Staff Professional Authority
Resolution 36 - Authority of the Medical Staff
Resolution 18 - Medical Wills
Resolution 19 - AMA Support System for the Direction, Growth and Development of Non-Profit Hospitals
Substitute Resolution 22 - Bylaws: A Guide for Hospital Medical Staffs withdraw and re-write by AMA
Resolution 67 - Hospital Requirements for Medical Staff Physician Professional Liability Insurance
Substitute Resolution 45 - Funding of Malpractice

During the past six months, the HMSS Governing Council studied numerous resolutions and submitted several reports to the assembly. The summary of these reports and the entire proceedings are available on request at the District Society. ■

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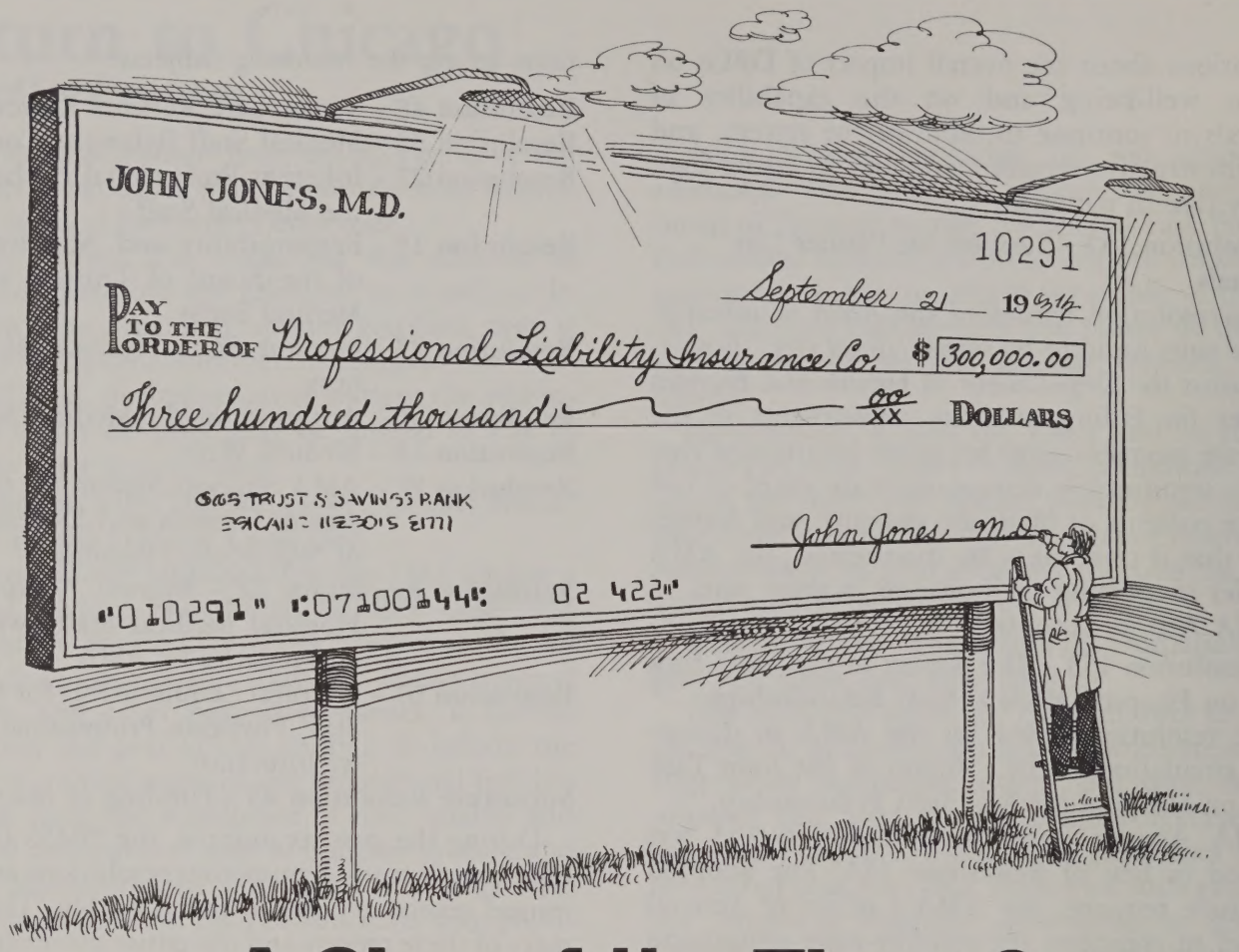
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A Sign of the Times?

In 1983, 22 physician-owned professional liability insurance companies were forced to raise their premiums an average of 17 percent. At that rate, high-risk insurance coverage that cost $63,000 in 1983 could top $300,000 in just ten years.

These costs are leading to an affordability crisis which affects everyone. Physicians are concerned about rising premiums, exorbitant awards and continued insurance availability. Patients pay the price in increased costs and limited access to care.

Liability problems exact a high toll on physicians—in time and money, and even on their health. Some have been forced into early retirement; others have modified their practices to avoid high-risk procedures.

There is help. The American Medical Association's Special Task Force on Professional Liability and Insurance has developed an ambitious plan of action to respond to the crisis. This includes reviewing tort reform, working with the nation's policymakers to address the issue, promoting state coalitions to deal with the problem, distributing patient information materials and instructing physicians on how to avoid lawsuits.

If you want something done about the professional liability problem, become part of the solution: join the AMA.

For more information about membership, call toll-free 800/621-8335 (in Illinois, call collect 312/645-4783), or return this coupon to:

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Auxiliary News

"Two Hampden District Medical Society Auxiliary Members in Jail"

This past June sixth, Kathy Mouchantat and Lorraine Penhos went to the Hampden County Jail as members of a "Site Survey Team," to conduct interviews with the correctional officers and the prison inmates on matters relating to health care at the jail.

These on the spot, one on one interviews are part of a state program to evaluate health care and conditions in Massachusetts Correctional Institutions prior to reaccreditation.

The Massachusetts Medical Society's committee on Health Care in Correctional Institutions has utilized Mass. Medical Society Auxilians to implement this project.

Both Kathy and Lorrain felt that the reaccreditation interviews were a great learning and eye opening experience. They said it was like being in another world, seeing and talking first hand to the guards and inmates, adding that they were thankful to be able to leave, but would be only too happy to go back as "interviewers" any time! ■

Ginny Walthall
Lorraine Penhos

The 1985 Health Careers Scholarship Campaign Commences

The Auxiliary to the Hampden District Medical Society will conduct the Health Career Scholarship Drive September 15, 1985 through October 15, 1985.

The Auxiliary wants to thank all of the doctors and their spouses who have contributed so generously over the past thirty-one years to the Scholarship Drives. To date over $67,000 has been awarded to Nursing and Paramedical students. Just think of the impact that this program has had on health care in Hampden County.

Each year there is an increase in the cost of education and each year there is an increase in the number of requests for scholarship aid. There are over six hundred doctors in the Hampden County Medical Society and if everyone of them contributed to this drive, we could help many more qualified and worthy students.

Please do contribute to the Health Career Scholarship Fund Drive. ■

Virginia Walthall, President H.D.M.A.
Kathy Mouchantat, Scholarship Treasurer
Lorraine Penhos, Chairperson
Scholarship Committee
Carolyn Letteney, Chairperson of
Career Scholarship Fund Drive

"Trusts and Tax Sheltered Investments"

A FINANCIAL SEMINAR
presented by The Auxiliary to H.D.M.S.

Tuesday, October 22, 1985
9:15 A.M. through luncheon
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Speakers:
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Chairperson:
Audrey Rich

This program is offered as a follow-up to last years' successful Financial Seminar and will be of interest to all age groups. The seminar will be conducted by professionals for the non-professional who is interested in acquiring a clearer understanding of the uses of tax shelters and trust funds. Don't miss this one! ■

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Farewell To The SMA 12

By Donald J. Higby, M.D. Chief, Hematology/Oncology Services
Baystate Medical Center

I am in the middle of my medical career. During my first exposure to clinical medicine, we were taught to order chemistry tests in a "rational" manner. Even before I finished medical school, however, the "SMA-12" became standard in our institution, and we were soon instructed, in no uncertain terms, to order SMA-12's if we wanted more than two of the tests on the panel, because this was more cost-effective. The automated system could perform all 12 tests for less than it would cost to perform two tests by hand!

The SMA-12 extended the physician's ability to follow the patient. With cancer patients, a glance could tell me something about organ toxicity from chemotherapy drugs; about the possibility of the disease progressing; I would have early warning about potentially serious complications; I could assess nutritional status, renal function, and so on. The routine SMA-12 became part of the surveillance of the patient, on a par with interim history and directed physical examination.

I and most of my colleagues trained during and after the introduction of automated testing soon began to recognize patterns; the SMA-12 was a useful diagnostic tool. I would suspect that many of the observations that have been made about disease prognosis came about because of the "extraneous" tests which were routinely observed by clinicians. Would the correlation between the lactic dehydrogenase level and the prognosis of malignant lymphoma have been discovered if this test were not routinely reported when another test had been the primary reason for ordering the panel? Would we have learned that in the absence of liver enzyme elevations, the asymptomatic patient with a primary carcinoma of the breast has a "cost-ineffective" chance of having a positive liver scan? Would we still be obtaining bone scans on such patients routinely, had we not learned that in the absence of an alkaline phosphatese elevation, the chance of such scans being positive would be less than 2%? There is still an untapped wealth of clinical information in old records where SMA-12's can be related to the progression and regression of disease; several recent publications have developed prognostic information based upon multivariate analysis of such information.

The SMA-12 extended the physician's ability to follow the patient. With cancer patients, a glance could tell me something about organ toxicity from chemotherapy drugs; about the possibility of the disease progressing; I would have early warning about potentially serious complications; I could assess nutritional status, renal function, and so on. The routine SMA-12 became part of the surveillance of the patient, on a par with interim history and directed physical examination.

Our institution has brought on-line a new system for performing serum chemistries. The system permits the laboratory technician to key in the specific tests desired, and those are then automatically performed. Looking over the broad range of diagnostic categories present in our hospital, our cost accountants decided that, when SMA-12's were ordered, the physician usually wanted only one or two values. For reasons which I am entirely unable to grasp, they set the costs of the new testing procedures so that one could order (for the same price as an old "SMA-12") four and one-half tests with the current system. We no longer can order the twelve tests without specifying them each; this undoubtedly will save costs, since each time I set out to order tests, I think hard about what I really need to know. But no longer can I expect "routine chemistries" to tip me off regarding a potential problem because of insidiously developing hypercalcemia. Unless I specifically order it, I may not be warned that liver function is beginning to deteriorate, and perhaps I should seek to define a relapse, and change my treatment strategy. Should I order a BUN when I order a creatinine? I've always relied on their relative values to decide whether my patient had pre-renal vs. renal azotemia. Which of

Continued on next page

The SMA 12

Continued from previous page

the four "liver function" tests should I abandon in my routine screening?

The relatively inexpensive SMA-12 has extended my clinical senses, and has probably been instrumental in saving a great deal of money with respect to tests I do not order because of what I have learned from clinical chemistries. The new scenario will be to order only those tests for which a clear indication exists. If one is abnormal, then I will order a few more, thus delaying by a day that point at which I make a major diagnostic or therapeutic decision. I will probably miss a few things I used to pick up before they caused problems to the patient. Third parties will undoubtedly disallow reimbursement for some of the tests I order, since in retrospect, they will prove not to have been necessary. However, I am sure that our cost accountants will be able to show that the number of clinical chemistry tests ordered is less than during the era of "SMA-12's", and probably, that the expenses associated with the chemistry laboratory have been lowered.

Perhaps the next step should be to charge for parts of the physical examination and history; ten dollars for auscultation of the chest; five for abdominal palpitation; seven-fifty for doing a "review of systems". At that point, our cost accountants can tell us that if we just stick to the meat of the history and physical as it pertains to the patient's presenting complaint, we will save money. After all, for many patients, a good part of the history and physical do not contribute to the management of the problem. ■

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Medicine Through The Years

by Margaret Stoler, Springfield Academy of Medicine

In conjunction with the 1986 Physician Portrait Fund Drive, a series of articles will appear in the Hippocrat giving an overall view of the development of medicine from the colonial period to the present.

1686-1736

By the late 17th century those practising medicine were not just ministers, barbers, tavern keepers and midwives; Savage's GENEOLOGICAL DICTIONARY claims there were 134 medical practitioners in all of the colonies in 1694. Included in the list were 5 school teachers, 4 weavers, 1 poet and a "woman employed by her own sex."

In England, medical practitioners were separated into categories; University trained physicians were the only ones who could bear the title of doctor and become members of a medical society; apothecaries were next in the status level, forming very powerful guilds which regulated charges for their potions; the lowest rung on the ladder were the barber surgeons and midwives; both were considered craftsmen and had no organization to support them.

In the colonies, the majority of practising physicians were craftsmen. Of the 3000 physicians practising in America from 1607 to 1776 less than 400 had received medical degrees from European schools. The earliest law distinguishing those who received a diploma in medicine and those who had no degree occurred in Virginia Assembly in 1736 stating "Surgeons and apothecaries who have studied physic in any University and taken any degree therein..." were permitted to charge higher rates. Interestingly, Yale began giving honorary Doctor of Medicine degrees in 1723 when Daniel Turner, a practising surgeon, donated a large collection of books to the college and in return was awarded an honorary degree. There was no medical department at Yale until 1813.

In the earlier part of the 18th century, those wishing to practice medicine would serve as an apprentice under a practising physician for three years and then receive a certificate allowing him to treat patients. Apprenticeship consisted of two separate categories which were "reading medicine" and "riding medicine". The titles are self explanatory. What is not mentioned is the chores assumed by the young apprentices which included gathering herbs, pounding drugs, mixing plasters, sweeping the office floor and caring for the doctor's horse. As with most apprenticeships, the ability of the teacher determined the degree of learning of the apprentice unless he sought extra sources of learning on his own. Such was the case of John Bard in Philadelphia who apprenticed under Hezakia Judson who frequently over imbibed. Bard is credited with performing the first successful operation on an ectopic pregnancy.

Though the practice of medicine was open to any man after a few years training, the minister was still the one most trusted and most frequently solicited. Perhaps one reason was that he rarely charged for his services. Ministers, politicians and merchants were the community leaders and in that order of status. Of the 862 Harvard graduates between 1642 and 1720, only 39 practised medicine and of those, 15 did it as a side occupation. As Cotton Mather affirms in his treatise BONIFACIUS: AN ESSAY UPON THE GOOD:

> "Tis an angelical conjunction when the ministers who do the pleasures of CHRIST shall also be physicians and Raphaels until their people."

He maintained that disease was primarily caused by sin and that cure was in repentance and prayer.

No doubt prayer was preferred over many of the remedies frequently used. In the December 18th, 1733 edition of the Boston Gazette is an advertisement for a book entitled, EXAMPLES OF GREAT MEDICINE, with the following subtitles; "Medicine out of Soot, Medical Virtures of Human Urine, Use of Horse Dung" (the juices of which were good for stoppage of urine and certain other complaints). There was even a remedy for excessive sorrow, an herbal mixture concocted by the Rev.

Continued on next page

Medicine Through The Years

Continued from previous page

Samuel Willard who recommended it be made available at funerals.

The inevitable challenge between the minister physician and the university trained physician occurred in Boston in 1721 when Zabdiel Bolyston introduced innoculation against small pox. His paper entitled "Some Account of What is Said of Inoculation or Transplanting the Small Pox" is considered the first introduction to public education of medical affairs. His staunchest supporter was Cotton Mather who was a member of the Royal Society of Science and had read about the Turks practising innoculation successfully for several years. Just as strongly opposed to the practice was Dr. William Douglass, a Scottish physician and graduate of Edinburgh University, the only university trained physician in the city at the time. So strongly did Boylston believe in innoculation that his first patient was his six year old son.

Hostilities between the two factions reached such a peak that both the Mather and Boylston homes were pelted with rocks by Douglass supporters. This violence brought both to their senses and Boylston was permitted to proceed with the patients willing to be innoculated. Towards the end of the century, innoculation retreats became centers of social activity with whole families entering for their week long stay. Some retreats were quite elegant, charging up to $15.00 a week. The innoculation controversy represented the first major challenge to ministers playing the role of physician, resulting in the formation of the first medical society in the colonies, "The Society of Physician Anti-Inoculars".

In western Massachusetts, the earliest paid practitioner was John Sherman, a school master who in 1709 ministered to Mr. Maillifield who, unfortunately died but who, fortunately, left his entire estate to the "Widows and Orphaned Children of Springfield." The first trained physician in Springfield was Dr. John Leonard who attended to the indigent from 1728 until his death in 1744. Deerfield's first physician was a cordwainer by the name of Dr. Thomas Wells who could not have successfuly practised without the aide of an apothecary, having received 245 preparations between 1733 and 1740, all different, and 38 for the same patient! The village of Northfield was outraged in 1735 when their minister persisted in practising medicine and demanded he cease and desist else they would find a new one. Statistics are sparse during this period. Upon perusing the records of Hadley, they revealed that the fee for blood letting in 1730 was six pence and only eight pence in 1776.

This was an important period in the development of medicine in America. By overcoming the influence of the pulpit, medicine could begin searching for its own identity, for a place of its own in the ever changing world.

1986 Physician Portrait

In 1986, the city of Springfield will be celebrating its 350th Anniversary. In response to the city wide celebration, the Springfield Academy of Medicine is planning to add another painting to their present collection which depicts the changes occuring in the field of medicine every 50 years beginning in 1636.

Consequently, the Academy is starting a fund drive towards creating a new painting depicting the changes in the field of medicine since 1936. Your help is badly needed and will be greatly appreciated. Please make your donations payable to *1986 Physician Portrait* and mail it to:

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1985 Annual Meeting of the AMA House of Delegates

Six hundred sixty-six delegates, representing all segments of American physicians, met in Chicago Jun 16-20 to respond to the myriad problems facing American medicine today. Retiring President Joseph Boyle stated that he felt the membership had regained confidence in the AMA and that the public was regaining confidence in medicine as a caring profession, but most of the delegates acted as if embattled. The major issues appeared to be professional liability insurance, financing graduate medical education and regulation by government and corporations.

The predicted physician surplus was discussed from many points of view. One major policy shift was a loss of faith in "marketplace regulation" and a move to planned action in selected areas. State and national studies were initiated to propose AMA recommendations in regards to licensing, support of undergraduate medical education, and residency training. The political pressure brought on licensing boards on U.S. citizens trained abroad was decried. The Board of Trustees will investigate the rumor that competition for residency positions is resulting in salary cuts and creation of "voluntary" positions for residency training. The final vote of the convention was a strong endorsement of indemnity payment of physician's fees, a change from the pluralistic policy previously espoused.

Dues to national associations account for .32% of an average physician's income compared to .75% of a chiropractor's income. Are your priorities intact? The AMA's priorities are.

The discussions of professional liability insurance were cheered by the passage of a tort reform act by the Illinois legislature during the meeting. Less encouraging was the report of withdrawal of care from parts of upstate New York and a reported annual 1985-86 premium for Florida obstetricians in the assigned risk pool of $195,000. The AMA still encourages state activities but has now prepared federal professional liability legislation essentially identical to the MMS package. A rebuttal to the American Trial Lawyers Association's widely publicized comments is being prepared. The charge to the Special Task Force was expanded to include a public information campaign. Although some predicted that the affordability crisis will get worse before it gets better, others are emphasizing the appearance of allies and pockets of public comprehension of the current plight of the "high-risk specialties."

On the regulation front, the House of Delegates condemned DRG's, mandatory fee schedules, Medicare policies on nursing home visits, the Medicare fee freeze and economically motivated patient transfers. One striking change was a decision to approve existing JCAH regulations as preferable to what might happen should changes be recommended.

It is not surprising that some of these changes have left the AMA in a schizoid posture. Although still committed to the academic freedom of medical schools, the AMA now strongly recommends courses in geriatric medicine, sexually transmitted diseases and child abuse for undergraduates, and socioeconomic training for residents. Although officially committed to increasing participation of women in organized medicine, none of the five female candidates for trustee or council membership were elected.

The delegates performed well in exposing abuses in the health care system. It was reported that Paracelsus Hospital of Hollywood, California is paying individual staff physicians a sizeable percentage of hospital DRG profits from patient understays. This was condemned by the delegates, the Judicial Council and Dr. Sammons, the Executive Vice-President. HCFA's declared intention to prosecute physicians who forgive patient's Medicare co-payments and deductibles will be combated. It was noted that some allied health practitioners are providing excessive services in the home to Medicare patients. This can be done only with a physician's written permission and I urge all of you to watch out for this practice. If a home health care plan is submitted to you for approval be sure that the patient really needs the services. A simple notation that the patient is not home-bound will prevent abusive behavior. Governmental doublespeak was attacked by urging the substitution of

"prospective pricing system" for "prospective payment system" and the term "contract physician provider" for "preferred provider".

Despite the fee freeze and the relative decline of physicians' income, the delegates approved a $45 increase in 1986 dues to an annual level of $375. Considering the actions on the 231 items of business discussed at the annual meeting, I feel that it is money well spent. Since 58% of AMA income comes from non-dues sources, members are getting $2 of representation, educational support and membership benefits for each $1 of dues. Of course, more members would mean lower dues and I urge all HDMS members who are not AMA members to reconsider this untenable position. Dues to national associations account for .32% of an average physician's income compared to .75% of a chiropractor's income. Are your priorities intact? The AMA's priorities are. ■

Respectfully submitted,
Garry deN Hough, III, M.D.
Alternate Delegate

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A Medical Message *on the Professional Liability Crisis*

We doctors know that a professional liability crisis exists, but now it's up to all of us to get behind an effective information campaign to dispel the notion that the crisis is merely a "pocketbook issue" for physicians. We need to get the word out—and fast.

Despite our best efforts, the perception still exists that there is no professional liability crisis. Usually this misconception is held by those who claim that doctor negligence is the only reason for the professional liability crisis.

These views are inaccurate and must be corrected. Of course, there are instances of negligence, but they do not account for the increasing numbers of suits filed. We need to educate the public through objective data on the number of claims, severity of claims and the rapidly climbing cost of insurance premiums—all of which document the crisis. We need to tell the public how this directly affects them. We need to spell out how patients are indirectly affected by the out-of-control cost of professional liability insurance.

Patients pay for a large portion of professional liability costs—in doctors' increased overhead, through "defensive" practices and in the staggering waste of an inefficient legal system that often benefits lawyers more than injured plaintiffs. The public also pays for a system that is encouraging, almost forcing, physicians to get out of high-risk specialties because of the increased chance of being sued as well as the high-priced premiums. We know some doctors are refusing to treat high-risk patients because of this fear, and we know that new physicians are steering clear of some specialties.

The American Medical Association's Task Force on Professional Liability and Insurance has taken an important step in addressing the situation with the recent release of three in-depth reports that document how serious the problem is and what proposals —legislative and otherwise—must be put into action to get available and affordable health care back on track.

Our efforts are best directed toward support of proposals that provide incentives to states to make changes. The AMA's legislative proposals refine the way in which damages are awarded and improve the liability resolution process. Among some specific judicial reforms proposed are the elimination of punitive damages in professional liability suits; limiting awards for "pain and suffering" and "mental anguish;" payment of damage awards periodically rather than in one lump sum; and restriction on the percentage of awards that go to the plaintiff's lawyer.

All the legislative reform proposals are detailed in the three professional liability reports. But much more is being done. An education and community action plan has been launched that will arm state, local and specialty medical societies with information to carry the professional liability message to the public. A pamphlet for patients explaining how the problem affects their medical care and its cost is available for physician's offices. In addition, the AMA has intensified its role as the physician's national representative on the issue with a strong advocacy program and now serves as a clearinghouse for data and legislative information.

These activities will go far in helping to solve the problem—but not far enough. We must take responsibility for the medical profession. We must stand behind reasonable legislative and voluntary efforts to police the profession and take whatever steps necessary to weed out incompetance in our ranks.

If the professional liability crisis were only a pocketbook issue for physicians, it wouldn't qualify as a crisis. But it is a crisis because it is not limited to physicians. It directly affects the cost and availability of medical care for all Americans. And it's up to us to get that message out. ■

AMA News

GREATER SPRINGFIELD HEALTH CARE COALITION

Alternate Delivery Systems Buyer's Guide

Prepared by The Alternate Delivery Systems Committee

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This is the second installment of this document. Please see the June-July 1985 for sections I and II. Section IV will appear in the next issue.

III. BUYER'S GUIDE

Having reviewed the basic definitions, history and background of HMOs and PPOs, we are now ready to provide to the corporate decision maker those issues which will help determine the appropriate plan of action: stay with an insured program, move toward HMOs, move toward PPOs, or provide to your employees some combination of options.

There is no single right answer. As the information which follows indicates, each approach has its own advantages and disadvantages—corporate priorities will ultimately determine the most reasonable course.

This guide has been divided into three parts: first, a comparison between HMOs and insured plans, PPOs and insured plans, and HMOs and PPOs. If a decision is made to move toward HMOs, the second part gives you a list of questions that can be asked to select the best HMO available. If your decision is to proceed along the PPO route, a similar set of questions has been provided in the third part to direct you toward those PPOs with the most desirable characteristics.

CHOOSING BETWEEN HMOs, PPOs, AND INSURED PLANS

1. HMOs vs. Traditional Insured Plans

The following are usual ADVANTAGES OF HMOs as compared to traditional insured plans.

* a) They're generally *less expensive* to the employer because of tight utilization controls and built-in incentives for doctors to use less medical facilities.

* b) They generally offer *broader benefit coverage* to the employees.

* c) There is generally *less employee out-of-pocket cost.* Most HMP plans provide first dollar coverage with only minimal co-payment.

d) Because of better utilization control, there is less inappropriate hospital admissions and therefore *lower absenteeism.*

e) There is generally *less paperwork* for the employee *in submitting claims.*

f) There may be *improved preventive services* which promote early diagnosis and treatment of medical problems.

g) There may be *better health education.*

The following are usual ADVANTAGES OF TRADITIONAL INSURED PLANS as compared to HMOs.

a) There is generally *greater accessibility to health care services* in all geographic locations.

b) There is *freedom of choice to select or change one's physician.*

c) There is *freedom of choice to go directly to a specialist.*

d) Benefit plans can be *tailored to employees' specifications*—this cannot be done by an HMO.

Continued on next page

Alternate Delivery Systems Buyer's Guide

Continued from previous page

e) *Utilization controls* such as pre-admission review, second surgical opinion *can be selected as options*—not a required part of the plan.

f) Traditional insurance plans *allow for self insurance.*

g) Larger employers' *good claims experiences are reflected in dividends and lower insurance premiums*—most HMOs are not experience rated.

h) Some suggest that HMOs rates will go up to the level of insured plans as the HMOs begin to insure more of the higher risk, older population.

* All three of the above mentioned advantages may not be present within a single HMO—some HMOs have a bias toward expanded benefits, others toward lower costs.

2. PPOs vs. Traditional Insured Plans

The following are usual ADVANTAGES OF PPOs as compared to traditional insurance plans.

* a) They're *generally less expensive* to the employer because of doctor and hospital discounts and built in utilization control programs.

* b) For those employees using a preferred doctor /hospital, there is *generally broader benefit coverage.*

* c) For those employees using a preferred doctor /hospital, there is *generally reduced out-of-pocket costs.*

d) Because of better utilization control, there is less inappropriate hospital admissions and therefore *lower absenteeism.*

e) For the employees using a preferred doctor/ hospital, there is generally *less paperwork in submitting claims.*

f) PPOs contain the threat for the employer that the healthy employees will move to the HMO, leaving only the sick in the insured plan—*PPOs retain the healthy in the insured plan.*

The following are USUAL ADVANTAGES OF TRADITIONAL INSURED PLANS as compared to PPOs.

a) An employer *may not want to subject his employees to utilization review* programs (pre-admission review, second surgical opinion, etc.). Under traditional insurance, these programs are optional.

b) Traditional insurance plans may be *less expensive to administer* because PPOs generally involve added expense for claims processing and/or utilization control.

c) An employer may not want to offer a PPO because of an *unsettled regulatory environment.* If PPOs are restricted in the future, employee health plans might have to be changed.

* All three of these advantages may not be present within a single PPO—some PPOs have a bias toward expanded benefits, others toward lower costs.

3. HMOs vs. PPOs

The following are USUAL ADVANTAGES OF HMOs AS COMPARED TO PPOs.

a) HMOs are *generally less expensive* because all employees are subject to utilization controls and lower provider costs—not just those that select a preferred provider.

b) HMOs generally offer broader benefit coverage—PPO coverage often is similar to the traditional insurance plan.

c) HMOs generally have stronger and more comprehensive utilization control because physicians have a financial stake in the quantity of services provided.

d) HMOs operate in a more stable and understood regulatory environment.

e) HMOs have a history of effectiveness and a solid track record in cost containment—PPOs are relatively new and, therefore, no historical record is yet available.

The following are the usual ADVANTAGES OF PPOs AS COMPARED TO HMOs.

a) PPOs offer greater accessibility to a doctor or specialist of choice. If an employee goes to a doctor not part of the HMO, there is no coverage.

b) PPOs offer a *choice to the employer in selecting a plan of benefits.*

c) PPOs offer a *choice to the employer to be self-insured.*

d) PPOs for large employers *are experience rated* —good claims experience accrues to the employer. Good experience in an HMO environment generally accrues to the HMO owners.

e) Some suggest that *HMOs are more susceptible to underutilization by doctors*—the more hospital admissions, the less is earned by the HMO.

CRITERIA FOR HMO SELECTION

Once you've determined to offer an HMO option to your employees, you may want to consider the following questions in selecting your HMO.

1. FINANCIAL SOUNDNESS
   Massachusetts Regulation 176G contains tests of financial stability. While a 176G license does not guarantee long term financial solvency, it is a good test of HMO soundness. All Massachusetts HMOs must receive 176G licenses.
2. INDEMNIFICATION
   Will HMO include indemnification clause in contract to protect employees from loss of benefits in the event the HMO went bankrupt or out of business?
3. TYPE OF HMO
   Is HMO closed panel (staff model) or open panel (IPA)?
   NOTE: Closed panel HMOs generally offer the advantage of tighter utilization controls and lower costs. IPAs generally provide a better freedom of choice in selecting a physician.
4. QUALITY OF CARE
   How is quality of care monitored? What are the professional education requirements and selection criteria for providers?
5. ACCESS
   How many hospital facilities are associated with the HMO?
   Which hospital facilities are associated with the HMO?
   Are there enough physicians and health care professionals to service the enrolled population?
   Is there an adequate supply of specialists associated with the HMO?
   Is 24 hour service available?
   How are emergency situations handled?
   NOTE: When reviewing the question of HMO access, it may be useful to check with other employers who are offering HMOs—are there employee complaints of waiting too long to see a primary physician or of not being able to obtain the assistance of a specialist?
6. COMPREHENSIVENESS OF BENEFITS
   What services are covered under the plan?
   Are well baby services covered?

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Continued from previous page

Are prescription drugs covered?
How are out of area injuries and illnesses covered?
What types of health education programs are offered?
How are highly specialized diagnostic and treatment services available only outside of the area covered?
How are medical supplies and durable equipment covered?
Is extended covalescent, skilled nursing care covered?
Is private duty nursing covered, and under what circumstances?
Is home health care covered, and under what circumstances?
Is dental covered, and under what circumstances?
Are mental health services covered, and under what circumstances?
Are substance abuse services covered, and under what circumstances?
NOTE: It may be just as useful to ask what services are not covered.

7. LEVEL OF CO-PAYMENTS
What is the level of co-payment for services rendered?
Does the employee have to remit a copayment when visiting the HMO?
8. SERVICE REIMBURSEMENT
Does the HMO work on a capitation or fee-for-service basis with their doctors?
NOTE: If doctors work on a capitation basis, thy have a financial incentive to reduce utilization and keep down increasing hospital admissions. The counter argument is that capitation may result in underutilization—less test scheduled, a reluctance to admit a patient to the hospital.
9. RATING
Will the HMO community or experience rate your group?
NOTE: All federally qualified HMOs must be community rated. An employer's specific claims experience is not reflected in next year's rates.
10. GRIEVANCE PROCEDURES
What system is in place for investigating and adjudicating members' grievances?
11. TRACK RECORD
How long has the HMO been in existence?
How many enrollees in the plan?
Have the HMOs rates remained fairly stable and not outpaced medical inflation?
What is the HMO's track record with respect to controlling utilization? What is their admission rate per thousand? Days of care rate per thousand covered individuals?
NOTE: Typical admission rates per thousand for HMOs are 85-90 admissions. Typical days of care range per thousand for HMOs are 438 to 450 days.
12. ELIGIBILITY
What size employer groups can avail themselves of HMOs?
Are retirees covered?
How are Medicare recipients covered?

CRITERIA FOR PPO SELECTION

1. FINANCIAL SOUNDNESS

How stable is the PPO financially?
Who owns the PPO and what is the financial status of that entity?
Does the PPO have sufficient capital to continue operations in the event there is inadequate enrollment to support ongoing operations costs?
NOTE: You may want to request financial statements if you're unsure of PPO viability.

2. TYPE OF PPOs
Is the PPO carrier based, provider based, or entrepreneurial?
NOTE: If the PPO is carrier based, there is generally health benefit expertise and a good probability of effective claim administrative systems. However, utilization control expertiese may be limited. Carrier based PPOs generally require that the employer be a client of the insurance carrier.
If the PPO is provider based, there is generally strong participation from physicians and hospitals. There is a potential in this model for a conflict between the provider goals of retaining and expanding market share and the need to control cost through utilization review.
If the PPO is entrepreneurial, it is independent of carrier and provider pressure, but may have difficulty in sustaining capital requirements for growth.
3. GROWTH
How is quality of care monitored?
What are the professional education requirements and selection criteria for providers?

4. ACCESS
   How many hospital facilities are associated with the PPO?
   Which hospital ficilities are associated with the PPO?
   Are there enough physicians and paraprofessionals participating in the program to service the enrolled population?
   Is there an adequate supply of specialists participating in the PPO?
   Is 24 hour service available?
   How are emergency situations handled?
5. COMPREHENSIVENESS OF BENEFITS
   NOTE: This is generally not an issue in selecting a PPO. The level of benefits associated with the PPO is often the same as the employee's insured plan of benefits. Sometimes special preventive care benefits (i.e. well baby cae, pap smear reimbursement) are offered to those that go to preferred providers.
6. PARTICIPATING PROVIDER REIMBURSEMENT
   What types of reimbursement arrangements have been negotiated with hospital providers? per diems? discounts? per procedure rates? How do these compare to standard charges?
   What types of reimbursement arrangements have been negotiated with physicians? straight discounts? per procedure rates? Do these differ between primary care providers and specialists? How do these compare to standard charges?
   What types of reimbursement arrangements have been negotiated with other providers, if any, such as pharmacies, nursing and therapy services, lab and x-ray services, dentists, mental health services, and home health care specialists. How do these compare to standard charges?
7. RATING/FEES
   Are there additional fees to the employers for PPO participation?
   If so, what do they cover?
   Are there additional administrative expenses incurred in insurance premium on separately billed?
8. GRIEVANCE PROCEDURES
   What system is in place for investigating and adjudicating enrollee grievances?
9. TRACK RECORD
   How long has the PPO been in existence?
   How many enrollees in the plan?
   What percentage of dollars has been saved on hospital expenses? from negotiated reim-

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Continued from previous page

bursement? from utilization savings?
What percentage of dollars has been saved on physician expenses? from negotiated reimbursements? from utilization savings?
What is the PPO's track record with respect to controlling utilization? What is their admission rate per thousand? days of care rate per thousand covered individuals?

10. UTILIZATION CONTROLS
Does the PPO have:
Preadmission certification
Continued stay review
Discharge planning
Second surgical opinion
Outpatient surgery requirements
Ambulatory service review
Physician referral pattern monitoring
Physician hospital admission pattern monitoring

11. CLAIMS HANDLING
Is the PPO system paperless for the employee, or does the employee have to submit a claim's form?

12. EMPLOYEE EDUCATION
What materials are provided to educate employees and encourage their use of preferred providers?
Will the PPO provide on-site assistance with employee education?
Does the PPO have an 800 number or other facility for responding to employee questions?

13. INTERFACE WITH CARRIER/CLAIMS ADMINISTRATOR
If provider-based or entrepreneurial model PPO, can it interface with carrier or claims administrator for claims payment and reporting, employee eligibility changes (adds and terminations), etc.?
NOTE: It should be determined whether it is the employer's or the PPO's responsibility to link to the insurance carrier's computer and claims system.

14. ELIGIBILITY
What size employer groups can avail themselves of PPOs?
Are retirees covered?
How are Medicare recipients covered? ■

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Notes And Quotes of Interest:

AMA to Co-Host Conference on Young Physician Stress

CHICAGO—Residency training is intensely stressful for young physicians. About a third of all residents are likely to suffer severe clinical depression during their first year, and some may turn to substance abuse.

To look at innovative ways teaching hospitals attempt to reduce the incidence of physician stress and abuse, the American Medical Association and the University of Illinois at Chicago are cosponsoring the Third Annual Conference on Stress, Impairment and the Resident, October 24-26, 1985, at the Harrison Conference Center in Lake Bluff, Illinois.

Sessions will focus on:

- educational benefits of feedback in clinical residency training
- an innovative housestaff stress management program
- the impact of a residency on the physician's home and family life
- sources of "emotional funding" for young physicians
- alternatives to traditional intern and resident staffing schedules
- increasing the managerial skills of residents

Not All Lab Tests Are Created Equal

Different commerical lab tests can give statistically different test results on the same specimen, according to a study appearing in the August *Archives of Pathology and Laboratory Medicine*. Benjamin Gerson, MD, of Harvard Medical School, and Mary Ann Figoni, MT (ASCP), of New England Deaconess Hospital, tested quantitation of glucose in human serum, plasma, or whole blood. Compared were products of Beckman Instruments, Eastman Kodak, Seralyzer System and Dextrostix strips of Ames Co. Statistically different and medically important differences were noted, suggesting that results can not necessarily be used interchangeably.

Dementia More Common in Women, Older Persons

The incidence of severe senile dementia of the Alzheimer's type increases with advanced age and has a higher prevalence among women, according to a study in the August *Archives of Neurology*. Bruce S. Schoenberg, MD, DrPH, of the National Institute of Neurological and Communicative Disorders and Stroke, and colleagues studied the prevalence of severe dementia among residents of Copiah County, Mississippi. Of nearly 24,000 residents, 80 had severe dementia, and 35 of these were in institutions. Incidence rose from 1 percent among persons aged 40 and older to 7 percent in those aged 80 or more. Prevalence ratios for females were about twice as high as for males, the researchers say, noting that prevalence is a function of both incidence and survival. "The major magnitude of this debilitating disorder demands important attention as the elderly segment of the United States population continues to increase in size," they say.

Medical Alert: *Prescription for Action,* the AMA's 1985 Political Education Conference, will be held September 18 and 19 in Washington, D.C. The

Continued on next page

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Notes And Quotes Of Interest:

Continued from previous page

focus of the one-and-a-half day conference is grassroots politiking; teaching the medical community how to become effective participants in the legislative and political arena.

Conference workshops cover such diverse topics as how to join candidate support committees, involvement in politics on a limited time budget and becoming a key congressional contact in organized medicine's legislative battles.

In addition, conferees will hear how other professional groups translate grassroots efforts into legislative and political success and gain an insiders' view of party politics as well as the upcoming 1986 Congressiona elections.

And, as one of the first groups to hold a private reception in the new Hart Senate Office Building on Capitol Hill, conferees will have the opportunity to meet face-to-face with elected representatives and important political officials. The Congressional Reception offers an exquisite view of the Capitol Dome and the chance to speak with those who count in a more intimate setting.

Further information and registration materials are available by contacting the AMA Division of Political Education, 1101 Vermont Avenue, N.W., Washington, D.C. 20005, (202)842-8442.

H.D.M.S. Medical Ethics Forum

The Medico-Religious Committee of the Hampden District Medical Society is sponsoring a Medical Ethics Forum on Wednesday, September 11, 1985 at the Chapin Auditorium of Springfield Municipal Hospital. The Forum will run from 6:30 to 9:30 p.m.

Professor Arthur J. Dyck, Professor of Population Ethics at the School of Public Health, Harvard University and Professor at the Divinity School at Harvard, will be the main speaker. His topic will be *Medical Ethical Dilemmas* and will address care for the dying - the process of ethical decision making, and the relation between "medical" and "ethical" judgements - and organ donations.

Area physicians, clergy, registered nurses, and licensed practical nurses, social workers and nursing students will be invited. Three Category I credits will be awarded to physicians by the Springfield Academy of Medicine. Fee for this Forum is $5.00 with pre-registration necessary. To receive further information call the Society's office at 736-0661.

For Immediate Release:

Medical, health professionals, and consumer leaders are invited to participate in a provocative FORUM on consumer health fraud in New England on Tuesday, October 22, 1985 9:30a.m. to 1:00p.m. at Western New England College, Law School, Sleith Hall, Springfield, MA.

For program information and reservations please write to:

Diane DiPiero, Chairperson, F.N.C.
Consumer Health Fraud Forum
55 State Street
Springfield, MA 01103

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Welcome New Members

Rita Iovino, M.D.
759 Chestnut St.
Springfield, MA 01107 RESIDENT

BORN:	May 6, 1956
PREMED:	Brooklyn College 1972-75, New York University Grad. School of Arts & Science
MEDICAL:	Downstate Medical School, 1976-80
INTERNSHIP:	University of Vermont Hospital, Burlington, VT 1980-83
RESIDENCY:	University of Connecticut 1983-84 7/85-present, Baystate Medical Center
SPECIALTY:	PEDIATRICS

Morris C. Lainer, M.D.
444 Montgomery St.
Chicopee, MA 01020

BORN:	March 19, 1952
PREMED:	University of Miami 1970-74
MEDICAL:	University of Massachusetts 1974-78
INTERNSHIP:	St. Vincents Hospital, Worcester 1978-79
RESIDENCY:	St. Vincents Hospital, Worcester 1979-81
SPECIALTY:	INTERNAL MEDICINE

Jay S. Steingrub, M.D.
759 Chestnut St.
Springfield, MA 01107

BORN:	February 29, 1952
PREMED:	SUNY at Buffalo, 1969-73
MEDICAL:	SUNY Upstate Medical Center, Syracuse 1973-77
INTERNSHIP:	Rochester General Hospital, University of Rochester School of Medicine & Dentistry, 1977-78
RESIDENCY:	Rochester General Hospital 1978-80
FELLOWSHIP:	University Health Center of Pittsburgh, Division of Critical Care Medicine 1980-82
SPECIALTY:	INTERNAL MEDICINE/CRITICAL CARE

Marjorie A. Lewis
759 Chestnut St.
Springfield, MA 01107 RESIDENT

BORN:	April 28, 1957
PREMED:	New College of University of Florida 1975-79
MEDICAL:	University of Florida 1979-81
INTERNSHIP:	Baystate Medical Center 1984-present
SPECIALTY:	GENERAL SURGERY

Amy P. Opfell, M.D.
759 Chestnut St.
Springfield, MA 01107 INTERN

BORN:	July 4, 1957
PREMED:	University of Southern California 1975-79
MEDICAL:	Universidad Autonoma de Guadalajar 1980-84
INTERNSHIP:	Baystate Medical Center - present

Cynthia L. Matthews-Betts, M.D.
759 Chestnut St.
Springfield, MA 01107 INTERN

BORN:	February 24, 1959
PREMED:	Trinity College, Hartford 1977-81
MEDICAL:	Howard University, Washington, DC 1981-85
INTERNSHIP:	Baystate Medical Center - present

Charles C. Bittle, Jr., M.D.
759 Chestnut St.
Springfield, MA 01107 INTERN

BORN:	July 30, 1959
PREMED:	Saint Mary's University of San Antonio, Texas 1977-80
MEDICAL:	University of Texas, Health Science Ctr. at San Antonio, Texas 1980-84
INTERNSHIP:	Baystate Medical Center, 7/85-present

Continued on next page

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Anastasios G. Angelides, M.D.
780 Chestnut St.
Springfield, MA 01107

BORN:	April 25, 1949
PREMED:	City College of New York 1966-70
MEDICAL:	University of Athens, Greece 1970-75
INTERNSHIP:	Long Island College Hospital 1975-76
RESIDENCY:	Long Island College 1976-79
FELLOWSHIP:	Indiana University Reley Children's Hospital, Indianapolis, Indiana 1979-81
SPECIALTY:	GASTROENTEROLGY/PEDIATRIC

Anne B. Morris, M.D.
759 Chestnut St.
Springfield, MA 01107 RESIDENT

BORN:	April 28, 1957
PREMED:	Emery University, Atlanta Georgia 1972-78
MEDICAL:	Medical College of Georgia, Augusta Georgia 1979-84
INTERNSHIP:	Baystate Medical Center 7/84-6/85
RESIDENCY:	Baystate Medical Center 7/85-present

Eugene F. Boss, M.D.
336 Longhill St.
Springfield, MA 01108

BORN:	May 27, 1954
PREMED:	Boston College, Chestnut Hill, MA 1972-76
MEDICAL:	University of Massachusetts 1976-80
INTERNSHIP:	St. Vincents Hospital, Worcester 1980-81
RESIDENCY:	St. Vincents Hospital, Worcester 1981-83
SPECIALTY:	INTERNAL MEDICINE

Nathaniel W. Hyde, M.D.
759 Chestnut St.
Springfield, MA 01107 RESIDENT

BORN:	November 22, 1949
PREMED:	U. of Vermont, Burlington 1968-72
MEDICAL:	Central University of East San Pedro de Marcoris, Dominican Republic 1975-79
INTERNSHIP:	Worcester City Hospital 1980-81
RESIDENCY:	Baystate Medical Center 1981-present
SPECIALTY:	GENERAL SURGERY

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SPRINGFIELD PUBLIC HEALTH DEPARTMENT

The Smith Trust Program

By John J. Cipolla, Health Commissioner

Dr. David P. Smith died in 1878. He had a son who died from illness at nine years of age. In memory of his son, Dr. Smith willed to the City of Springfield the right to use the interest from his estate "to provide health care for the poor children of Springfield." Thus, the David P. Smith Memorial Fund was established.

Mayor Neal has proclaimed that these funds should be used to lower the infant mortality rate of Springfield - which is purported to be among the highest in the Commonwealth of Massachusetts. He has decided to allow the Commissioner of Public Health to establish a community wide program which would have the specific objective of lowering Springfield's Infant Mortality Rate.

The Public Health Department is currently involved with the Baystate Wesson Women Center's staff, Springfield's private and public maternal and infant health agencies, and civic organizations in coordinating a city wide attack on the problems of Infant Mortality. Based upon recommendations of a task force report, submitted by Dr. Egan, the conceptual framework for a comprehensive multiple agency attack plan on the problems is evolving. That concept envisions all aspects of problems which impact upon infant mortality to be addressed—namely, the medical, social, psychological, educational, environmental and political. It calls not only for agencies to establish themselves as comprehensively coordinated units for planning purposes along, but to share their resources for the purpose of attaining a common objective—to provide maternal and infant care services which will serve *all* the women and children in Springfield.

The Public Health Department is currently involved with the Baystate Wesson Women Center's staff, Springfield's private and public maternal and infant health agencies, and civic organizations in coordinating a city wide attack on the problems of Infant Mortality.

Towards this end, the Mayor has directed the Public Health Commissioner to prepare the reconstruction of the former T.B. Sanitarian Hospital to become the center of activity for this bold venture. The Public Health Building will become known as the Public Health and Human Services Center.

Recognizing that the Smith Funds are limited, and that a comprehensive approach to basic health services requires more support than the trust can provide, the Mayor established a corporation which will allow public and private providers and agencies to function together. It is to be known as the SMITH Program Incorporated. He has mandated that the Commissioner of Health, with the collaboration of the Human Services Director, establish a comprehensive primary health care service program to coordinate the city's human service agencies. That program is currently underway. ■

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SUBJECT:	Reversing Atherosclerosis
DATE:	Monday, September 9, 1985
WHERE:	Providence Hospital Auditorium
TIME:	7:30 p.m.
CME CREDIT:	2 hours Category 1, Springfield Academy of Medicine

Dr. Stark has been certified by the American Board of Internal Medicine and ABIM Subspecialty Board in Cardiovascular Disease. Dr. Stark is Clinical Instructor in Medicine at Yale University School of Medicine.

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In Memoriam

JOSEPH BERNSTEIN, M.D.

Dr. Bernstein died May 24, 1985 at age 68. A graduate of the Royal College of Medicine in Edinborough, Scotland, he practiced general medicine for 10 years in Springfield. After a stint in the U.S. Army, he took a residency in psychiatry and returned to Springfield where he was active in District Court psychiatric clinics and consultant activities for civic and governmental facilities. A past president of the Western Mass. Psychiatric Association, he is survived by his wife, a son, a daughter, a sister and two grandchildren.

GEORGE D. BECKER, M.D.

Dr. Becker died July 13, 1985 at his home in Longmeadow at age 82. He was a 50 year member of both the Wesson and Mercy Hospital Medical Staffs. He graduated from Tufts Medical School and was a fellow of the American College of Surgeons. He leaves his wife, two sons, a daughter, a brother, a sister and five grandchildren.

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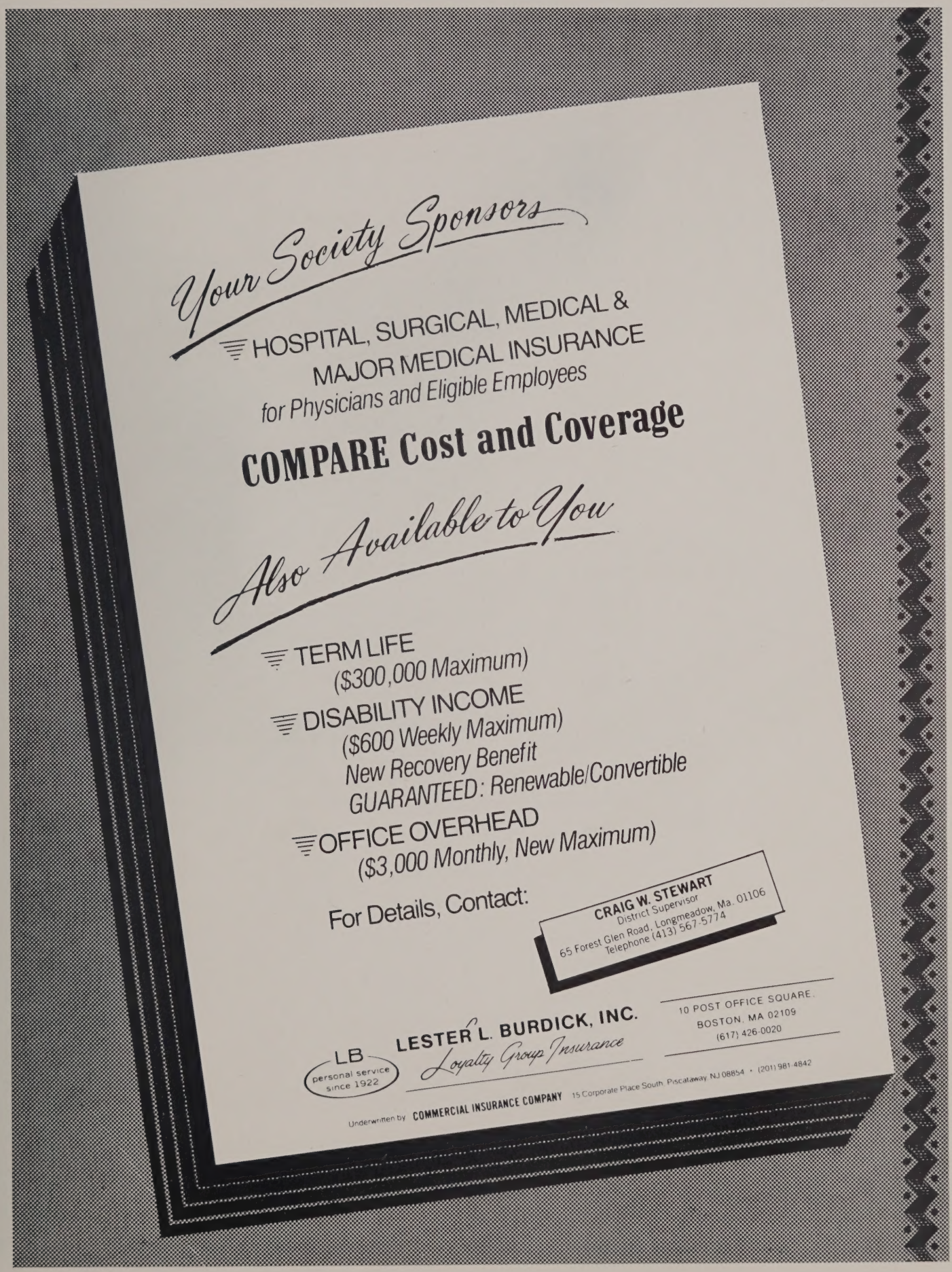
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